Stormy weather for Labour's NHS reforms

ANALYSIS

Autumn storms darkened Tony Blair's Britain. A tempest howled over the Hutton Enquiry, the war in Iraq and the state visit by George Bush. And mighty gusts shook to pieces the Labour government's most important domestic policy platform: reform of the National Health Service (NHS).

Shaking the foundation hospital

The first health policy plank prised loose was the foundation hospital. Department of Health guidelines published late last year promised greater freedom for top-performing NHS hospital trusts. Each hospital trust would be able to raise and expend funds in accordance with the priorities of governing bodies comprised of health service providers and residents of the area it served.

From the beginning, academics questioned the coherence of this move.[1,2] How could increased hospital financing and spending latitude (which includes the freedom to develop innovative pay and benefit schemes) be squared with a commitment to preserve equity throughout the system? Wouldn't the potentially stronger and freer hospital foundations raid the weaker nonfoundation hospitals for human resources? Was this not the path to a two-tier system?

The Department of Health responded by promising to keep foundation trusts on a short leash: they would be held accountable by clear performance measures and prohibited from uncharitable actions such as the sale of NHS assets. Little roaming room was left for innovation or capacity-building and, as the critics pointed out, no room at all for Labour's "social cooperative," a notion that promised citizen control, local accountability and democratization.

If the government's initial position on foundation trusts was muddled, it has not become clearer. Although the Department of Health lauds private fundraising, the Treasury has decreed that there will be no borrowing, private or public, by hospital foundations without express permission. Debt will be treated as Department of Health debt — that is, subject to an annual cap. Capital funding thus becomes a shell game. How net hospital capacity will increase under the new rules of the game is a mystery.

The trade unions have labelled foundation hospitals "at best a two-tier health service and at worst a staging post to privatisation."[3] Their conference in September was swiftly followed by the Labour Party conference, where a motion from the floor condemning government hospital policy received overwhelming support. In mid-October the past Health Secretary, Frank Dobson, waded in, encouraging the Lords to devise "a nuclear amendment" to the government's upcoming hospital bill.

The first applications for foundation status, 25 in all, prompted some existing trust hospitals (which currently fail to meet eligibility criteria) to fret that it may become impossible for them ever to attain foundation status if funds and human resources are diverted to the first-round applicants. Virtually no one in Britain now publicly supports foundation hospitals; indeed, almost no one purports to *understand* them. Blair, risking revolt from his own backbenchers, remains adamant that his government's plan will go forward, even if only in a diluted form.

National Health Service (NHS) trusts and foundations

Hospital trusts: These are publicly owned hospitals that emerged in the UK under the Conservative government's policy of purchaser–provider splits. Public hospitals, "the providers," were granted quasi-autonomous status from the health authorities, who became "the purchasers" of services provided by trusts. Thus, trusts were part of the NHS "quasi-market" and were forced to compete with one another for patients and funds. Since assuming office, the Labour government has discouraged competition between trusts in favour of more cooperative arrangements. For the past several years the performance of trusts has been closely monitored, and the government has published league tables based on a star system (0 to 3). Labour's idea is to foster competition among hospitals over quality rather than funding.

Foundation trusts: Top-performing hospital trusts can apply for foundation status and hence function as independent bodies in which local public accountability replaces central state control. They have increased freedom to retain operating surpluses and to access a wider range of options for capital funding to invest in the delivery of new services. They recruit and employ their own staff. Although they must deliver on national targets and standards like the rest of the NHS, they are free to decide how to achieve this and are not subject to direction by the Department of Health.

Primary care trusts: Under the Conservative government, GPs could apply for budgets to purchase hospital, pharmaceutical and consultant services on behalf of patients registered with their practice. The Labour government ended "GP fund holding" but retained the idea of commissioning services for patients in the form of primary care trusts. These trusts involve the horizontal integration of primary care (GP services, community nursing, community mental health care) at the local level. Like fund holders, primary care trusts receive budgets to purchase hospital, pharmaceutical, consultant and other services on behalf of the population they serve — from 57 000 to 334 000 people. They thus combine a direct service delivery role (primary care) with a purchasing and commissioning role (specialist, community and hospital care). Unlike fund holders, they do not compete for enrolees: place of residence determines the primary care trust responsible for care.

Beleaguered service standards

The second plank in Labour's NHS reform platform, the enforcement of service standards, has also been buffeted in the press. By September, complaints from doctors and managers about the perverse effects of targets such as a 4-hour limit on waits in emergency departments had begun to circulate. In a world of scarcity, the emergency-department rule drives up inappropriate admissions, withdraws care from serious cases so that the less needy can be ushered out the door within the time limit, and has disruptive knock-on effects in other services. Similarly, mandated maximum waiting times for diagnosis merely shifts a patient's wait for a first appointment to a delay between diagnosis and treatment.

The Department of Health complained that criticisms of its targets were unfair: doctors were not expected to comply in contexts where harm might ensue. That response was mocked: If targets are not intended to change behaviour, then what are they for?

Art Explosion

NHS reforms: room for Labour's "social cooperative"?

Although the government was forced in early September to back down on some existing targets and to promise more consultation on future ones, the controversy has not abated. In early November, ill-conceived targets and the enforcement of new government standards were blamed for patients being held in ambulances in hospital parking lots. The press alleged that some hospitals were planning to set up inflatable tents outside their doors, in part as a response to emergency care targets. The finger was also pointed at foundation trusts with allegations that the emergency care tents were part of efforts by trusts to meet performance targets and thereby become eligible for foundation status.

Private surgeries

Hoping to meet targets for elective surgery waiting times, Labour unveiled the diagnostic treatment centre initiative (DTC), the third plank in its NHS reform platform and the most windblown of all. Launching the DTC involved seeking proposals from vendors to deliver elective surgical procedures in specialized high-volume clinics. The government's goal was to add 250 000 cataract, joint replacement and minor surgical procedures by 2005.

Bids came from American, South African and English private companies, and from Calgary's Anglo-Canadian Clinics Ltd. (see page 183). Public understanding, bolstered by the Health Secretary's assurance, was that the bidders would provide the facilities and the staff — predominantly professionals recruited from abroad. It was also understood that the unit costs and hence the NHS payments per service would be lower than in NHS hospitals.

In the second week of September the media reported that the private DTC facilities would be allowed to hire up to 70% of their professional staff from the NHS, raising the question of how such an approach could possibly boost the health system's net capacity. The government was forced to admit, one day after the Health Secretary denied it, the possible poaching of NHS staff. A further admission was that government had agreed to pay the DTCs a premium of up to 15% over NHS rates. The obvious question was raised: Why wasn't this money offered to existing hospitals to establish specialized units? (Presumably, the answer lay in the government's private view of NHS hospitals as fiscal sinkholes beyond reform.) Further, hospital trusts, including some seeking foundation status, predicted that moving elective surgical patients out of their case mix and into DTCs would damage their hospital's clinical and educational programs and distort cost profiles. That provoked another row as a supposedly independent hospital trust, Oxford Eye Hospital, with the backing of 3 local primary care trusts and the strategic health authority, was ordered by government to give up 1000 eye patients to the planned private DTC.

The impression created by last autumn's news is that the Labour government is improvising without a clear plan. The felt need to control is mitigating the potential good of letting managers and clinicians take charge. Apart from welcome new money for the NHS and a robust commitment to medical school expansion (1000 new places this year alone — Canada take note), Labour's reforms of the NHS are in serious difficulty.

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